

REFERENCE TITLE: healthcare group; health plans; information

State of Arizona
Senate
Forty-eighth Legislature
Second Regular Session
2008

SB 1389

Introduced by
Senators Cheuvront, Allen

AN ACT

AMENDING SECTION 36-2912, ARIZONA REVISED STATUTES; AMENDING TITLE 36, CHAPTER 29, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTION 36-2912.04; RELATING TO THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:

Section 1. Section 36-2912, Arizona Revised Statutes, is amended to read:

36-2912. Healthcare group coverage: program requirements for small businesses and public employers: related requirements: definitions

A. The administration shall administer a healthcare group program to allow willing contractors to deliver health care services to persons defined as eligible pursuant to section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e). In the absence of a willing contractor, the administration may contract directly with any health care provider or entity. The administration may enter into a contract with another entity to provide administrative functions for the healthcare group program.

B. Employers with ~~one~~ TWO eligible ~~employee~~ EMPLOYEES or up to an average of fifty eligible employees under section 36-2901, paragraph 6, subdivision (d):

1. May contract with the administration to be the exclusive health benefit plan if the employer has five or fewer eligible employees and enrolls one hundred per cent of these employees into the health benefit plan.

2. May contract with the administration for coverage available pursuant to this section if the employer has six or more eligible employees and enrolls eighty per cent of these employees into the healthcare group program.

3. Shall have a minimum of one and a maximum of fifty eligible employees at the effective date of their first contract with the administration.

~~C. The administration shall not enroll an employer group in healthcare group sooner than one hundred eighty days after the date that the employer's health insurance coverage under an accountable health plan is discontinued. Enrollment in healthcare group is effective on the first day of the month after the one hundred eighty day period. This subsection does not apply to an employer group if the employer's accountable health plan discontinues offering the health plan of which the employer is a member.~~

~~D.~~ C. Employees with proof of other existing health care coverage who elect not to participate in the healthcare group program shall not be considered when determining the percentage of enrollment requirements under subsection B of this section if either:

1. Group health coverage is provided through a spouse, parent or legal guardian, or insured through individual insurance or another employer.

2. Medical assistance is provided by a government subsidized health care program.

3. Medical assistance is provided pursuant to section 36-2982, subsection I.

~~E.~~ D. An employer shall not offer coverage made available pursuant to this section to persons defined as eligible pursuant to section 36-2901,

1 paragraph 6, subdivision (b), (c), (d) or (e) as a substitute for a federally
2 designated plan.

3 ~~F.~~ E. An employee or dependent defined as eligible pursuant to
4 section 36-2901, paragraph 6, subdivision (b), (c), (d) or (e) may
5 participate in healthcare group on a voluntary basis only.

6 ~~G.~~ F. Notwithstanding subsection B, paragraph 2 of this section, the
7 administration shall adopt rules to allow a business that offers healthcare
8 group coverage pursuant to this section to continue coverage if it expands
9 its employment to include more than fifty employees.

10 ~~H.~~ G. The administration shall provide eligible employees with
11 disclosure information about the health benefit plan.

12 ~~I.~~ H. The director shall:

13 1. Require that any contractor that provides covered services to
14 persons defined as eligible pursuant to section 36-2901, paragraph 6,
15 subdivision (a) provide separate audited reports on the assets, liabilities
16 and financial status of any corporate activity involving providing coverage
17 pursuant to this section to persons defined as eligible pursuant to section
18 36-2901, paragraph 6, subdivision (b), (c), (d) or (e).

19 2. Beginning on July 1, 2005, require that a contractor, the
20 administration or an accountable health plan negotiate reimbursement rates
21 and not use the administration's reimbursement rates established pursuant to
22 section 36-2903.01, subsection H, ~~as~~ as a default reimbursement rate if a
23 contract does not exist between a contractor and a provider.

24 3. Use monies from the healthcare group fund established by section
25 36-2912.01 for the administration's costs of operating the healthcare group
26 program.

27 4. Ensure that the contractors are required to meet contract terms as
28 are necessary in the judgment of the director to ensure adequate performance
29 by the contractor. Contract provisions shall include, at a minimum, the
30 maintenance of deposits, performance bonds, financial reserves or other
31 financial security. The director may waive requirements for the posting of
32 bonds or security for contractors that have posted other security, equal to
33 or greater than that required for the healthcare group program, with the
34 administration or the department of insurance for the performance of health
35 service contracts if funds would be available to the administration from the
36 other security on the contractor's default. In waiving, or approving waivers
37 of, any requirements established pursuant to this section, the director shall
38 ensure that the administration has taken into account all the obligations to
39 which a contractor's security is associated. The director may also adopt
40 rules that provide for the withholding or forfeiture of payments to be made
41 to a contractor for the failure of the contractor to comply with provisions
42 of its contract or with provisions of adopted rules.

43 5. Adopt rules.

1 6. Provide reinsurance to the contractors for clean claims based on
2 thresholds established by the administration. For the purposes of this
3 paragraph, "clean claims" has the same meaning prescribed in section 36-2904.

4 ~~I.~~ I. With respect to services provided by contractors to persons
5 defined as eligible pursuant to section 36-2901, paragraph 6, subdivision
6 (b), (c), (d) or (e), a contractor is the payor of last resort and has the
7 same lien or subrogation rights as those held by health care services
8 organizations licensed pursuant to title 20, chapter 4, article 9.

9 ~~K.~~ J. The administration shall offer a health benefit plan on a
10 guaranteed issuance basis to small employers as required by this
11 section. All small employers qualify for this guaranteed offer of coverage.
12 The administration shall provide a health benefit plan to each small employer
13 without regard to health status-related factors if the small employer agrees
14 to make the premium payments and to satisfy any other reasonable provisions
15 of the plan and contract. The administration shall offer to all small
16 employers the available health benefit plan and shall accept any small
17 employer that applies and meets the eligibility requirements. In addition to
18 the requirements prescribed in this section, for any offering of any health
19 benefit plan to a small employer, as part of the administration's
20 solicitation and sales materials, the administration shall make a reasonable
21 disclosure to the employer of the availability of the information described
22 in this subsection and, on request of the employer, shall provide that
23 information to the employer. The administration shall provide information
24 concerning the following:

- 25 1. Provisions of coverage relating to the following, if applicable:
- 26 (a) The administration's right to establish premiums and to change
- 27 premium rates and the factors that may affect changes in premium rates.
- 28 (b) Renewability of coverage.
- 29 (c) Any preexisting condition exclusion.
- 30 (d) The geographic areas served by the contractor.
- 31 2. The benefits and premiums available under all health benefit plans
- 32 for which the employer is qualified.

33 ~~L.~~ K. The administration shall describe the information required by
34 subsection ~~K.~~ J of this section in language that is understandable by the
35 average small employer and with a level of detail that is sufficient to
36 reasonably inform a small employer of the employer's rights and obligations
37 under the health benefit plan. This requirement is satisfied if the
38 administration provides the following information:

- 39 1. An outline of coverage that describes the benefits in summary form.
- 40 2. The rate or rating schedule that applies to the product,
- 41 preexisting condition exclusion or affiliation period.
- 42 3. The minimum employer contribution and group participation rules
- 43 that apply to any particular type of coverage.
- 44 4. In the case of a network plan, a map or listing of the areas
- 45 served.

~~M.~~ L. A contractor is not required to disclose any information that is proprietary and protected trade secret information under applicable law.

~~N.~~ M. At least sixty days before the date of expiration of a health benefit plan, the administration shall provide a written notice to the employer of the terms for renewal of the plan.

~~O.~~ N. The administration may increase or decrease premiums based on actuarial reviews of the projected and actual costs of providing health care benefits to eligible members. Before changing premiums, the administration must give sixty days' written notice to the employer. The administration may cap the amount of the change.

~~P.~~ O. The administration may consider age, sex, income and community rating when it establishes premiums for the healthcare group program.

~~Q.~~ P. Except as provided in subsection ~~R.~~ Q of this section, a health benefit plan may not deny, limit or condition the coverage or benefits based on a person's health status-related factors or a lack of evidence of insurability.

~~R.~~ Q. A health benefit plan shall not exclude coverage for preexisting conditions, except that:

1. A health benefit plan may exclude coverage for preexisting conditions for a period of not more than twelve months or, in the case of a late enrollee, eighteen months. The exclusion of coverage does not apply to services that are furnished to newborns who were otherwise covered from the time of their birth or to persons who satisfy the portability requirements under this section.

2. The contractor shall reduce the period of any applicable preexisting condition exclusion by the aggregate of the periods of creditable coverage that apply to the individual.

~~S.~~ R. The contractor shall calculate creditable coverage according to the following:

1. The contractor shall give an individual credit for each portion of each month the individual was covered by creditable coverage.

2. The contractor shall not count a period of creditable coverage for an individual enrolled in a health benefit plan if after the period of coverage and before the enrollment date there were sixty-three consecutive days during which the individual was not covered under any creditable coverage.

3. The contractor shall give credit in the calculation of creditable coverage for any period that an individual is in a waiting period for any health coverage.

~~T.~~ S. The contractor shall not count a period of creditable coverage with respect to enrollment of an individual if, after the most recent period of creditable coverage and before the enrollment date, sixty-three consecutive days lapse during all of which the individual was not covered under any creditable coverage. The contractor shall not include in the determination of the period of continuous coverage described in this section

any period that an individual is in a waiting period for health insurance coverage offered by a health care insurer or is in a waiting period for benefits under a health benefit plan offered by a contractor. In determining the extent to which an individual has satisfied any portion of any applicable preexisting condition period, the contractor shall count a period of creditable coverage without regard to the specific benefits covered during that period. A contractor shall not impose any preexisting condition exclusion in the case of an individual who is covered under creditable coverage thirty-one days after the individual's date of birth. A contractor shall not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before age eighteen and who is covered under creditable coverage thirty-one days after the adoption or placement for adoption.

~~U.~~ T. The written certification provided by the administration must include:

1. The period of creditable coverage of the individual under the contractor and any applicable coverage under a COBRA continuation provision.
2. Any applicable waiting period or affiliation period imposed on an individual for any coverage under the health plan.

~~V.~~ U. The administration shall issue and accept a written certification of the period of creditable coverage of the individual that contains at least the following information:

1. The date that the certificate is issued.
2. The name of the individual or dependent for whom the certificate applies and any other information that is necessary to allow the issuer providing the coverage specified in the certificate to identify the individual, including the individual's identification number under the policy and the name of the policyholder if the certificate is for or includes a dependent.
3. The name, address and telephone number of the issuer providing the certificate.
4. The telephone number to call for further information regarding the certificate.
5. One of the following:
 - (a) A statement that the individual has at least eighteen months of creditable coverage. For THE purposes of this subdivision, eighteen months means five hundred forty-six days.
 - (b) Both the date that the individual first sought coverage, as evidenced by a substantially complete application, and the date that creditable coverage began.
6. The date creditable coverage ended, unless the certificate indicates that creditable coverage is continuing from the date of the certificate.

~~W.~~ V. The administration shall provide any certification pursuant to this section within thirty days after the event that triggered the issuance

1 of the certification. Periods of creditable coverage for an individual are
 2 established by presentation of the certifications in this section.

3 ~~X.~~ W. The healthcare group program shall comply with all applicable
 4 federal requirements.

5 ~~Y.~~ X. Healthcare group may pay a commission to an insurance
 6 producer. ~~To receive a commission, the producer must certify that to the~~
 7 ~~best of the producer's knowledge the employer group has not had insurance in~~
 8 ~~the one hundred eighty days before applying to healthcare group.~~ For the
 9 purposes of this subsection, "commission" means a one time payment on the
 10 initial enrollment of an employer.

11 ~~Z.~~ Y. On or before June 15 and November 15 of each year, the director
 12 shall submit a report to the joint legislative budget committee regarding the
 13 number and type of businesses participating in healthcare group and that
 14 includes updated information on healthcare group marketing activities. The
 15 director, within thirty days of implementation, shall notify the joint
 16 legislative budget committee of any changes in healthcare group benefits or
 17 cost sharing arrangements.

18 ~~AA.~~ Z. For the purposes of this section:

19 1. "Accountable health plan" has the same meaning prescribed in
 20 section 20-2301.

21 2. "COBRA continuation provision" means:

22 (a) Section 4980B, except subsection (f)(1) as it relates to pediatric
 23 vaccines, of the internal revenue code of 1986.

24 (b) Title I, subtitle B, part 6, except section 609, of the employee
 25 retirement income security act of 1974.

26 (c) Title XXII of the public health service act.

27 (d) Any similar provision of the law of this state or any other state.

28 3. "Creditable coverage" means coverage solely for an individual,
 29 other than limited benefits coverage, under any of the following:

30 (a) An employee welfare benefit plan that provides medical care to
 31 employees or the employees' dependents directly or through insurance,
 32 reimbursement or otherwise pursuant to the employee retirement income
 33 security act of 1974.

34 (b) A church plan as defined in the employee retirement income
 35 security act of 1974.

36 (c) A health benefits plan, as defined in section 20-2301, issued by a
 37 health plan.

38 (d) Part A or part B of title XVIII of the social security act.

39 (e) Title XIX of the social security act, other than coverage
 40 consisting solely of benefits under section 1928.

41 (f) Title 10, chapter 55 of the United States Code.

42 (g) A medical care program of the Indian health service or of a tribal
 43 organization.

44 (h) A health benefits risk pool operated by any state of the United
 45 States.

1 (i) A health plan offered pursuant to title 5, chapter 89 of the
2 United States Code.

3 (j) A public health plan as defined by federal law.

4 (k) A health benefit plan pursuant to section 5(e) of the peace corps
5 act (22 United States Code section 2504(e)).

6 (l) A policy or contract, including short-term limited duration
7 insurance, issued on an individual basis by an insurer, a health care
8 services organization, a hospital service corporation, a medical service
9 corporation or a hospital, medical, dental and optometric service corporation
10 or made available to persons defined as eligible under section 36-2901,
11 paragraph 6, subdivisions (b), (c), (d) and (e).

12 (m) A policy or contract issued by a health care insurer or the
13 administration to a member of a bona fide association.

14 4. "Eligible employee" means a person who is one of the following:

15 (a) Eligible pursuant to section 36-2901, paragraph 6, subdivisions
16 (b), (c), (d) and (e).

17 (b) A person who works for an employer for a minimum of twenty hours
18 per week or who is self-employed for at least twenty hours per week.

19 (c) An employee who elects coverage pursuant to section 36-2982,
20 subsection I. The restriction prohibiting employees employed by public
21 agencies prescribed in section 36-2982, subsection I does not apply to this
22 subdivision.

23 (d) A person who meets all of the eligibility requirements, who is
24 eligible for a federal health coverage tax credit pursuant to section 35 of
25 the internal revenue code of 1986 and who applies for health care coverage
26 through the healthcare group program. The requirement that a person be
27 employed with a small business that elects healthcare group coverage does not
28 apply to this eligibility group.

29 5. "Genetic information" means information about genes, gene products
30 and inherited characteristics that may derive from the individual or a family
31 member, including information regarding carrier status and information
32 derived from laboratory tests that identify mutations in specific genes or
33 chromosomes, physical medical examinations, family histories and direct
34 ~~analysis~~ ANALYSES of genes or chromosomes.

35 6. "Health benefit plan" means coverage offered by the administration
36 for the healthcare group program pursuant to this section.

37 7. "Health status-related factor" means any factor in relation to the
38 health of the individual or a dependent of the individual enrolled or to be
39 enrolled in a health plan including:

40 (a) Health status.

41 (b) Medical condition, including physical and mental illness.

42 (c) Claims experience.

43 (d) Receipt of health care.

44 (e) Medical history.

45 (f) Genetic information.

1 (g) Evidence of insurability, including conditions arising out of acts
2 of domestic violence as defined in section 20-448.

3 (h) The existence of a physical or mental disability.

4 8. "Hospital" means a health care institution licensed as a hospital
5 pursuant to chapter 4, article 2 of this title.

6 9. "Late enrollee" means an employee or dependent who requests
7 enrollment in a health benefit plan after the initial enrollment period that
8 is provided under the terms of the health benefit plan if the initial
9 enrollment period is at least thirty-one days. Coverage for a late enrollee
10 begins on the date the person becomes a dependent if a request for enrollment
11 is received within thirty-one days after the person becomes a dependent. An
12 employee or dependent shall not be considered a late enrollee if:

13 (a) The person:

14 (i) At the time of the initial enrollment period was covered under a
15 public or private health insurance policy or any other health benefit plan.

16 (ii) Lost coverage under a public or private health insurance policy
17 or any other health benefit plan due to the employee's termination of
18 employment or eligibility, the reduction in the number of hours of
19 employment, the termination of the other plan's coverage, the death of the
20 spouse, legal separation or divorce or the termination of employer
21 contributions toward the coverage.

22 (iii) Requests enrollment within thirty-one days after the termination
23 of creditable coverage that is provided under a COBRA continuation provision.

24 (iv) Requests enrollment within thirty-one days after the date of
25 marriage.

26 (b) The person is employed by an employer that offers multiple health
27 benefit plans and the person elects a different plan during an open
28 enrollment period.

29 (c) The person becomes a dependent of an eligible person through
30 marriage, birth, adoption or placement for adoption and requests enrollment
31 no later than thirty-one days after becoming a dependent.

32 10. "Preexisting condition" means a condition, regardless of the cause
33 of the condition, for which medical advice, diagnosis, care or treatment was
34 recommended or received within not more than six months before the date of
35 the enrollment of the individual under a health benefit plan issued by a
36 contractor. Preexisting condition does not include a genetic condition in
37 the absence of a diagnosis of the condition related to the genetic
38 information.

39 11. "Preexisting condition limitation" or "preexisting condition
40 exclusion" means a limitation or exclusion of benefits for a preexisting
41 condition under a health benefit plan offered by a contractor.

42 12. "Small employer" means an employer who employs at least one but not
43 more than fifty eligible employees on a typical business day during any one
44 calendar year.

13. "Waiting period" means the period that must pass before a potential participant or eligible employee in a health benefit plan offered by a health plan is eligible to be covered for benefits as determined by the individual's employer.

Sec. 2. Title 36, chapter 29, article 1, Arizona Revised Statutes, is amended by adding section 36-2912.04, to read:

36-2912.04. Medical loss subsidies; required information

THE ADMINISTRATION SHALL NOT PROVIDE ANY SUBSIDY TO AN ACCOUNTABLE HEALTH PLAN THAT IS UNDER CONTRACT TO PROVIDE SERVICES PURSUANT TO SECTION 36-2912 UNLESS THE ADMINISTRATION HAS APPROVED THE PLAN'S UTILIZATION MANAGEMENT CONTROLS AND THE PLAN CAN DOCUMENT TO THE ADMINISTRATION'S SATISFACTION THAT THE PLAN HAS IMPLEMENTED THE APPROVED UTILIZATION MANAGEMENT CONTROLS.

Sec. 3. Healthcare group; employee groups; continued eligibility

Notwithstanding section 36-2912, Arizona Revised Statutes, as amended by this act, an employee group of one eligible employee that was enrolled in healthcare group before the effective date of this act may continue to be enrolled in healthcare group if the employee group continues to meet all other applicable requirements for enrollment.

Sec. 4. Healthcare group task force; report

A. The healthcare group task force is established, consisting of the following members:

1. Five members of the senate who are appointed by the president of the senate, not more than three of whom are members of the same political party. The president of the senate shall designate one of these members to serve as cochairperson of the task force.

2. Five members of the house of representatives who are appointed by the speaker of the house of representatives, not more than three of whom are members of the same political party. The speaker of the house of representatives shall designate one of these members to serve as cochairperson of the task force

3. One representative of a health care insurance company who is appointed by the president of the senate.

4. One representative of a health care insurance company who is appointed by the speaker of the house of representatives.

5. One actuary with experience in health care rating who is appointed by the president of the senate.

6. One actuary with experience in health care rating who is appointed by the speaker of the house of representatives.

7. One representative of the small business community who is appointed by the speaker of the house of representatives.

8. One representative of the small business community who is appointed by the president of the senate.

1 9. The director of the Arizona health care cost containment system
2 administration or the director's designee.

3 10. The director of the department of insurance or the director's
4 designee.

5 B. The task force shall:

6 1. Examine the current management, operational and programmatic
7 structure of healthcare group, including administrative and financial
8 oversight, the medical loss reconciliation process, cost control mechanisms,
9 including utilization management controls, and performance measures.

10 2. Recommend management, operational and programmatic options designed
11 to ensure the ongoing financial stability and self-sufficiency of healthcare
12 group.

13 C. The task force shall submit a report of its findings and
14 recommendations to the governor, the president of the senate, the speaker of
15 the house of representatives and the joint legislative budget committee on or
16 before December 31, 2008 and shall submit a copy of its report to the
17 secretary of state and the director of the Arizona state library, archives
18 and public records.

19 D. Task force members are not eligible to receive compensation, but
20 public members are eligible for reimbursement of expenses under title 38,
21 chapter 4, article 2, Arizona Revised Statutes.

22 Sec. 5. Delayed repeal

23 Section 4 of this act, relating to the healthcare group task force, is
24 repealed from and after January 31, 2009.